Student Medical Information Form 2026 - 2027

Chicago Public Schools

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is CONFIDENTIAL and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F / M / X / N)	STUDENT DATE OF BIRTH	SCHOOL NAME

STUDENT ID #	GRADE	ROOM #

1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

☐ **YES** ☐ **NO**

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

☐ Allergies (food or other)

List Allergies: _____

☐ Asthma

Year Diagnosed _____

☐ Seizures/Epilepsy

Year Diagnosed _____

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other

Year Diagnosed _____

☐ Sickle Cell Disease

Year Diagnosed _____

☐ Other _____ Year Diagnosed _____

2. MY CHILD HAS A PRIMARY CARE PROVIDER ☐ YES ☐ NO

If yes, please provide the healthcare provider's name and phone number:

Name _____ **Phone number** _____

☐ **I give permission for my child's school nurse or designee to talk to the doctor about my child's health.**

3. MY CHILD IS COVERED BY HEALTH INSURANCE: ☐ YES ☐ NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437).

This form is NOT the same as a medical order, action plan, or plan of care. If your student has a health condition listed above, please visit cps.edu/oshw to view the CPS Health Forms required for that particular health condition. CPS Health Forms must be completed by a medical provider and submitted to the school nurse in order to keep your student healthy and safe at school. If you have any questions about required medical forms, please schedule a call or meeting with your school nurse.

Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.

Parent/Guardian Name _____ **Date** _____ **Phone Number** _____

Parent/Guardian Signature _____ **Email** _____

Nurses Use Only **Reviewed by (Initials)** _____ **Date** _____

Revised February 2025

RETAIN IN THE STUDENT HEALTH RECORD